PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, November 20, 2001, at 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard Koh (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Mr.Benjamin Rubin, Ms. Janet Slemenda and Dr. Thomas Sterne; Ms. Shane Kearney Masaschi and Ms. Maureen Pompeo absent; One vacancy. Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Joyce James, Director, Determination of Need Program; Ms. Deborah Allen, ScD, Director, Division of Special Health Needs, Ms. Cheryl Bushnell, RN, Director Office of Health and Disability, Bureau of Family and Community Health; and Ms. Malena Orejuela, MPH, Epidemiologist, Bureau of Health Statistics, Research and Evaluation.

RECORDS OF THE PUBLIC HEALTH COUNCIL EMERGENCY MEETING OF OCTOBER 10, 2001:

Records of the Public Health Council emergency meeting of October 10, 2001 were presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously): That, records of the Public Health Council emergency meeting of October 10, 2001, copies of which had been sent to the Council Members for their prior consideration, be approved, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A ½.

PERSONNEL ACTIONS:

In letters dated November 7, 2001, Katherine Domoto, MD, MBA, Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of appointments and reappointments to the medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments and reappointments to the various medical staffs of Tewksbury Hospital be approved for a period of two years beginning November 1, 2001 to November 1, 2003:

APPOINTMENTS:	**STATUS:**	**MED. LICENSE NO.:**
Jeffrey Doshier, M.D.	Provisional Affiliate	208573
Philip Simkowitz, M.D.	Provisional Allied	152536

REAPPOINTMENTS:	**STATUS:**	**MED. LICENSE NO.:**
Daniel Breslin, M.D.	Active	60138
Shirish Desai, M.D.	Active	40000
Kathleen Brady, M.D.	Affiliate	60484
Mithlesh Garg, PhD.	Allied	168

In a letter dated November 5, 2001, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of reappointments to the medical staff of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the reappointments to the medical staff of Western Massachusetts Hospital be approved as follows:

REAPPOINTMENTS:	**STATUS:**	**MED. LICENSE NO.:**
Philip Glynn, M.D.	Oncology/Hematology	57384
Howard Lederman, M.D.	Physiatry	81248
Alan Sampson, DMD	Oral Surgery	10596

In a letter dated November 8, 2001, John H. Britt, Executive Director, Massachusetts Hospital School, recommended approval of appointments to the provisional medical staff of Massachusetts Hospital School. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendations of the Executive Director of Massachusetts Hospital School, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointments to the provisional medical staff of Massachusetts Hospital School be approved as follows:

APPOINTMENTS:	**STATUS:**
Anton B. Dodek, M.D.	Provisional
Prachi E. Shah, M.D.	Provisional

STAFF PRESENTATIONS:

"A PROFILE OF ADULTS WITH DISABILITY IN MASSACHUSETTS, 1998-2000: RESULTS OF THE BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM", BY DEBORAH ALLEN, ScD, DIRECTOR, DIVISION OF SPECIAL HEALTH NEEDS, BUREAU OF FAMILY AND COMMUNITY HEALTH (BFCH), MONIKA MITRA, PhD, SENIOR ANALYST, OFFICE OF HEALTH AND DISABILITY, BFCH, NANCY WILBER, EdD, DIRECTOR, OFFICE OF STATISTICS AND EVALUATION, BFCH, PHYLLIS BRAWARSKY, MPH, RESEARCH ANALYST, BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, BHSRE, AND CHERYL BUSHNELL, RN, DIRECTOR, OFFICE OF HEALTH AND DISABILITY, BFCH:

Dr. Deborah Allen, ScD, Director, Division of Special Health Needs, Bureau of Family and Community Health said in part, "The Office of Health and Disability in the Massachusetts Department of Public Health is funded through a state capacity-building grant from the office of Disability and Health of the national Centers for Disease Control and Prevention. In 1997, Massachusetts was one of 14 states to receive a four-year grant which has permitted Massachusetts to sustain and build public health capacity to address health needs of individuals. The mission of the Massachusetts Office on Health and Disability (OHD) is to promote health and wellness for people with disabilities and to prevent "secondary conditions." This mission reflects the understanding that disability need not equal poor health; prevention and health promotion are as relevant for people with disabilities as for people without; and most secondary conditions – other health problems to which individuals with disabilities may be vulnerable, but which do not directly reflect their disabling condition are preventable."

Dr. Allen continued, "OHD goals, which form the basis for its program initiatives, are optimal health status for individuals with disabilities, full inclusion in community living for individuals with disabilities, and access to comprehensive, high quality care for individuals with disabilities. To achieve those goals, OHD seeks to build broad health and disability awareness among consumers, providers, and the public, to establish an informed health and disability constituency, and to expand access to public health services for individuals with disabilities. A fourth strategy, required to achieve the prior three, is to collect and disseminate data, which can clarify the prevalence of disability and to identify health and related needs of individuals with disabilities. This report is one part of our effort to achieve the fourth goal. It draws on data collected from a random sample of the Massachusetts population to characterize the impact of disability within the state. The report indicates that many Massachusetts residents live with disabilities and suggests that specific risks, such as smoking and obesity, which pose particular challenges for individuals with disabilities, are present at elevated levels among the population with disabilities. Finally, the data reveal the potential of public health efforts to improve health status and overall well-being of people with disabilities. The report on adults with disabilities in Massachusetts from 1998 to 2000 presents a profile of disability in

Massachusetts. The findings are based on results from the 1998, 1999, and 2000 Massachusetts Behavioral Risk Factor Surveillance Systems (BRFSS) surveys. The BRFSS survey collects information from a random sample of non-institutionalized Massachusetts adults, age 18 and older, on a variety of health issues including issues related to disability and quality of life.

In 1998-2000, the Massachusetts BRFSS included screening questions to identify adults with disabilities. These questions were:

- "Are you limited in any way in any activities because of any impairment or health problem?
- "Because of any impairment or health problem, do you have any trouble learning, remembering, or concentrating?"
- If you use special equipment or help from others to get around, what type do you use?"
- "Would you describe yourself as having a disability of any kind? A disability can be physical, mental, emotional, or communication-related."

Adults who answered yes to any of the screening questions were asked about the nature of their major impairment, health problem, or disability; how long their activities had been limited; and whether they needed the help of other persons in handling routine needs or personal care. Persons who responded yes to at least one of the screening questions and whose activities had been limited for at least one year were considered for this report as having disabilities. Persons with disabilities were classified into two groups: those who needed assistance in handling routine needs or personal care and those who did not need assistance. A total of 17,679 interviews that included questions on disability were conducted in 1998-2000 (4,944 in 1998, 7,287 in 1999, and 5,448 in 2000). Where possible, the information presented here is based on data from all years. However, some questions were not asked in all three years and thus only one or two years of data are available for some analyses. A total of 3,074 individuals in all three years were identified as having disabilities. Of these individuals, 868 needed assistance with routine needs or personal care. There were 12,676 individuals who did not have disabilities. Excluded from the analysis were 1,942 individuals because they could not be classified as having or not having a disability.…"

PREVALENCE:

Based on data from 1998-2000, 18% of the non-institutionalized Massachusetts adult population reported having a limitation or disability. The most common disabling condition was orthopedic problems (29%) followed by chronic conditions (18%), arthritis (12%), affective problems (8%), and sensory problems (7%). As expected, disability was more common among older adults.

HEALTH RISK BEHAVIORS:

An estimated 25% of adults with disabilities smoked compared to 19% of adults without disabilities. The percent of adults who smoked decreased with age for both groups.

Overall, adults with disabilities were slightly less likely to be binge drinkers (13%) than adults without disabilities. The percent of adults who smoked decreased with age for both groups. Overall, adults with disabilities were slightly less likely to be binge drinkers (13%) than adults without disabilities (19%). There was no difference in heavy drinking between adults with disabilities and adults without disabilities. Obesity was more common among adults with disabilities when compared to adults without disabilities. Adults with disabilities were also less likely to report leisure-time physical activity in the past month, compared to adults without disabilities.

HEALTH CARE ACCESS AND UTILIZATION:

Five percent of adults with and without disabilities were currently without health insurance. Having no insurance decreased with increasing age for both groups. However, individuals with disabilities were more likely to be underinsured compared to individuals without disabilities. Individuals with disabilities were slightly more likely to have seen a doctor for a routine check up in the previous year (86%) when compared to individuals without disabilities (77%). Similarly, adults with disabilities were more likely to have had a flu shot in the past year and to have ever received a pneumococcal vaccination compared to adults without disabilities. Individuals with disabilities were less likely to have seen a dentist in the past year and to have six or more teeth missing due to disease, when compared to individuals without disabilities. There was essentially no difference between adults with and without disabilities regarding breast, cervical, and prostate cancer screening. However, individuals with disabilities were more likely to ever had a proctoscopic exam (51%) compared to individuals without disabilities (42%). There was no difference in the percentage of people with and without disabilities with a high or medium risk of being infected with HIV. However, 27% of adults with disabilities were tested for HIV in the past year compared to 20% of adults without disabilities.

QUALITY OF LIFE:

One in every four (25%) adults with disabilities reported that pain limited activities for more than half of the previous month compared to only 2% of adults without disabilities. Adults with disabilities were also more likely to report being sad, blue, or depressed, have more days of insufficient sleep, and feel worried, tense, or anxious 15 or more days in the previous month when compared to adults without disabilities. Additionally, adults with disabilities were less likely to be satisfied with their life and feel healthy and full of energy compared to adults without disabilities. Among women 18-59, women with disabilities were twice as likely to have experienced intimate partner abuse in the past year (10%), when compared to women without disabilities (5%). Intimate partner abuse decreased with increasing age for both groups of women. Women with disabilities were also much more likely to ever have experienced sexual assault compared to women without disabilities.

HEALTH STATUS:

One in every three adults with disabilities described their health as fair or poor compared to five percent of adults without disabilities. Both physical and mental health were strongly associated with disability status. A similar association was found between disability status and health interferring with usual activities. Adults with disabilities had fewer healthy days in the previous month when compared to adults without disabilities. Persons with disabilities were more likely to have diabetes, heart disease, high blood pressure, and high cholesterol than non-disabled persons. Moreover, among women age 45 and older, osteoporosis was more common among women with disabilities, when compared to women without disabilities.

"HISPANIC BIRTHS IN MASSACHUSETTS 1996-1999", BY MALENA OREJUELA, MPH, EPIDEMIOLOGIST, BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION:

Ms. Malena Orejuela, MPH, Epidemiologist, Bureau of Health Statistics, Research and Evaluation, presented the "Hispanic Births in Massachusetts 1996-1999." She said in part, "…The Hispanic population in Massachusetts is large and heterogeneous. Grouping all Spanish-speaking people together into one undifferentiated community does not fully account for intercultural distinctions. There is more variation among the different Hispanic groups in health status and outcomes than between the Hispanic population overall and racial groups such as White non-Hispanics. These differences within the Hispanic population have substantial implications for health program development and health policy. Overall, Salvadoran and Puerto Rican mothers were more likely than other Hispanic groups to have specific characteristics that may be associated with adverse birth outcomes. Puerto Rican mothers were more likely to be under the age of 20, less likely to breastfeed and more likely to smoke during pregnancy than White non-Hispanic and other Hispanic mothers. In addition, Salvadoran and Puerto Rican mothers were less educated, had the lowest percentages of adequate prenatal care and one of the highest percentages of public funding for this care, compared with other Hispanic groups as well as with White non-Hispanic mothers…."

DEMOGRAPHICS:

According to the 2000 U.S. Census, there were 428,729 Hispanics living in Massachusetts, constituting about 7% of the total population. The Puerto Rican population comprised the largest group, with approximately 47% of all Hispanics in Massachusetts. Puerto Ricans were followed by Other Hispanics (19%), Dominicans (12%), Mexicans (5%), Other Central American (5%), Salvadorans (4%), Other South American (4%), Colombians (3%), and Cubans (2%). The Hispanic population was the largest minority group and the second fastest growing population group in Massachusetts. While the overall population growth in Massachusetts was only 5% between 1980 and 1990, the Hispanic population grew 104%, from141,043 to 287,549. For the period between 1990 and 2000, the Hispanic population continued to be the second fastest growing population (49%) in Massachusetts. A 76% increase in the number of Mexicans and a 72% increase in the number of "Other Hispanics" fueled much of the nearly 142,000 increase in the number of Hispanics between 1990 and 2000. This growth varied

substantially by geographic location within Massachusetts. According to 2000 Census data, the Hispanic population continued to be concentrated in urban areas, but the Hispanic population was somewhat more dispersed than in 1990. Within communities where Hispanics resided, the distribution of ethnicity groups varied enormously. For instance, in Springfield and Holyoke, the largest group was Puerto Rican (85% and 88 %, respectively), while in Somerville, 31% of the Hispanic population were Salvadorans. The percent of the population that is of Hispanic ethnicity also varied greatly by community. The Hispanic population in Lawrence accounted for 60% of the total population of that city. In comparison, the Hispanic population in Chelsea, Holyoke, Springfield, Worcester and Boston accounted for 48%, 41%, 27%, 15% and 14%, of the total populations in those cities. Based on 1990 Census data, Hispanics had a lower percentage of college graduates compared with the state overall and also a higher percentage of persons with less than a high school education. In addition, Hispanics had a lower average household income in 1990 and a higher proportion below the poverty level than the statewide averages.

BIRTHS:

During 1996 through 1999, there were 33,437 births among Massachusetts women of Hispanic ancestry, constituting 10% of all births in the state. The majority of these births occurred among women of Puerto Rican ancestry (52%), followed by Dominican (17%), Other Central American (7%), Salvadoran (7%) and Other South American (5%). The average annual number of births to Massachusetts women of Mexican ethnicity increased by 153%, from 123 to 311, between the periods 1986-1987 and 1996-1999. Likewise, the number of births to Puerto Rican and Dominican mothers increased by 28% and 111%, respectively, between these two time periods. In contrast, average annual births to Cuban women declined by 20% between the two time periods – from 108 per year in 1986-1987 to 86 per year in 1996-1999. Six out of every ten Hispanic births in Massachusetts were concentrated among residents of 6 cities: Boston, Lawrence, Springfield, Worcester, Holyoke and Chelsea. Over one-third of all Hispanic births in the state occurred at three hospitals: Baystate Medical Center, Brigham and Women's Hospital and Lawrence General Hospital (13%, 13%, and 9%, respectively).

MATERNAL DEMOGRAPHICS:

Hispanic mothers were more likely to be teenagers than White non-Hispanic mothers in the state. Twenty-nine percent of Puerto Rican mothers were under the age of 20, compared with 5% of White non-Hispanic mothers. "Other Hispanic" (21%), Dominican (15%), and Salvadoran (12%) mothers were also more likely to be under 20 years old than White non-Hispanic mothers. Hispanic mothers were less likely to be married when they gave birth than White non-Hispanic mothers. Sixty-one percent of all Hispanic mothers were unmarried compared to 18% of White non-Hispanic mothers. Puerto Rican mothers had the highest percent of unmarried mothers, 72%, while "Other South American" mothers had the lowest, 23%. The majority of Hispanic mothers were not born in the continental U.S., with the exception of Cuban and "Other Hispanic" (51% and 70%, respectively, were continental U.S. –born). The majority of Hispanic mothers also

indicated a preference for the English language rather than Spanish (ranging from 51% for Mexican mothers to 86% for Cuban mothers). However, Dominican, Colombian, Salvadoran and "Other Central American" mothers preferred Spanish to English (ranging from 61% for Colombian mothers to 82% for Salvadoran mothers). Almost 90% of mothers who classified their ethnicity as Hispanic also classified themselves as "Other Race". These percentages were lowest for Cuban and "Other South American" mothers (56% and 61%, respectively); thirty-seven percent of Cuban mothers and 34% of "Other South American" mothers classified themselves as White. Hispanic mothers, on average, had less formal education than White non-Hispanic mothers, with a lower percentage of college graduates and a higher percentage of women with less than a high school education. Cuban and "other South American" mothers had the highest percentages of more than a college education (16% and 12%, respectively), which were comparable to White non-Hispanic mothers (13%). Compared to continental U.S.-born Hispanic mothers, non-continental U.S.-born Hispanic mothers had lower percentages of unmarried mothers (56% vs. 72%), teenage mothers (under 20) (16% vs. 32%), and preference for the English language (39% vs. 86%). In contrast, a lower percentage of continental U.S.-born Hispanic mothers had less than a high school education (27% vs. 34%).

MATERNAL RISK FACTORS:

From 1996 to 1999, mothers of Hispanic ethnicity were less likely to smoke both prior to and during pregnancy than White non-Hispanic mothers. The percentage of Hispanic mothers smoking during pregnancy varied greatly, ranging from 1% to 14%, averaging 9% overall. Puerto Rican mothers had the highest rate of smoking during pregnancy when compared to other Hispanic groups. Salvadoran women had the lowest rate of smoking during pregnancy, at less than 1%. Hispanic mothers born in the continental U.S., had a higher rate of smoking during pregnancy (16%) than mothers born outside the continental U.S. (5%). The prevalence of selected medical risk factors was higher among Hispanic mothers. These conditions were anemia, diabetes, and hypertension. Almost 5% of Hispanic mothers (range 2.2% to 5.3%) as compared to 1.3% of White non-Hispanic mothers had anemia reported. The percentage of Hispanic mothers reporting diabetes ranged from 2.4% to 4.4%, averaging 3.7%. "Other Hispanic" (5.7%) and Cuban (5.6%) mothers had hypertension reported in a higher proportion than White non-Hispanic mothers (3.9%). Proportions of mothers reporting hypertension in the seven other Hispanic groups were comparable to that of White non-Hispanic mothers, ranging from 2.8% to 3.9%. "Other South American, Colombian and Cuban mothers had higher percentages of delivery by Cesarean section than White non-Hispanic mothers did.

PRENATAL CARE:

Sixty-six percent of all Hispanic mothers received adequate prenatal care. This percentage ranged from 59% to 82% depending on the mother's ethnicity. "Other Hispanic" and Cuban mothers had percentages comparable to White non-Hispanic mothers (83%). Salvadoran and Puerto Rican mothers had the lowest adequate prenatal care percentages, 59% and 64%, respectively. Hispanic mothers in some of the larger,

urban communities such as Lawrence (51%), New Bedford (56%), Brockton (57%) and Springfield (58%) had lower percentages of adequate prenatal care than the statewide average for all Hispanic mothers (66%). Source of payment for prenatal care varied substantially by mother's ethnicity. Seventy-five percent of Puerto Rican and Dominican mothers and 71% of Salvadoran mothers had prenatal care paid with public funds, compared with only 28% of Cuban mothers, 38% of "Other South American" mothers, and 16% of White non-Hispanic mothers. For most Hispanic groups, the majority of mothers received their prenatal care at physicians' offices rather than at hospital clinics or community health centers. This was true to "Other South American" (61%), Cuban (60%), Mexican (54%), Colombian (46%), Puerto Rican (43%), "Other Hispanic" (40%), and Dominican mothers (33%). However, Salvadoran and "Other Central American" mothers were more likely to receive their prenatal care at a community health center (55% and 36%, respectively). The percentages of Hispanic mothers receiving prenatal care at physicians' offices were lower than for White non-Hispanic mothers (83%).

BREASTFEEDING:

Hispanic mothers reported higher percentages of breastfeeding (range of 73% to 87%) than White non-Hispanics (70%) with the exception of Puerto Rican mothers who had the lowest percentage (60%). Salvadoran and "Other South American" mothers had the highest percentage of breastfeeding (87%). Non-continental U.S.-born Hispanic mothers had higher percentages for breastfeeding (77% vs. 59%) than continental U.S.-born Hispanic mothers.

LOW BIRTHWEIGHT:

The incidence of low birthweight infants varied across Hispanic ethnicities. Hispanic mothers, with the exception of Colombians, had higher percentages of low birthweight infants (weighing less than 5.5 pounds) than White non-Hispanic mothers in Massachusetts (6.%). "Other Hispanic" mothers had the highest percentage of low birthweight infants (10.5%) when compared to all other Hispanic groups and to White non-Hispanics mothers. Hispanic mothers in Brockton (11.2%), Springfield (10.2%) and Framingham (9.8%) had the highest percentages of low birthweight infants among communities with the highest number of Hispanic births. Non-continental U.S.-born Hispanic mothers had lower percentages of low birthweight infants (7.6 vs. 8.9%) than continental U.S.-born Hispanic mothers.

PRETERM BIRTHS:

The percentages of preterm births (births before 37 weeks of gestation) also varied by ethnic group. Overall, with the exception of Mexican, Colombian and "Other South American" mothers, Hispanic mothers had a higher proportion of premature births than White non-Hispanic mothers (6.8%). Nine percent of Hispanic mothers delivered preterm infants. Percentages were highest for "Other Hispanic" mothers (11.5%). Among selected cities and towns with the highest number of Hispanic births, Hispanic mothers in Springfield (12.1%), Chicopee (12.1%) and Leominster (9.8) had the highest

percentages of preterm births. Hispanic mothers born outside of the continental U.S. had a lower percentage of preterm births (8.4%) than Hispanic mothers born in the continental U.S.

INFORMATIONAL ONLY – NO VOTE

Note – "HISPANIC BIRTHS IN MASSACHUSETTS 1996-1999, Volume I: Statewide Data and Volume II: Selected City and Town Data" were distributed to the Council Members at the meeting.

DETERMINATION OF NEED PROGRAM:

COMPLIANCE MEMORANDUM:

PREVIOUSLY APPROVED DON PROJECTS NO. 4-1390 OF FRANK WOOD CONVALESCENT HOME AND NO. 4-1397 OF SHERRILL HOUSE, INC. – REQUEST FOR SIGNIFICANT CHANGES TO INCREASE IN THE MAXIMUM CAPITAL EXPENDITURE AND ELIMINATE THE 20% EQUITY CONTRIBUTION OF THE CONSOLIDATED PROJECTS AT THE SHERRILL HOUSE SITE:

Ms. Joyce James, Director, Determination of Need Program, said, "We are recommending approval of the request by the Sherrill House to increase the maximum capital expenditure and eliminate a conditional proposal for equity contribution for a project that has previously been approved, but not yet implemented. We find that the increase in the maximum capital expenditure was unforeseen at the time the initial amendment was filed. That amendment was based on preliminary plan design and development of the project. With final architectural plans and specifications completed and put out for bid, the actual capital cost estimate of the project was determined…Additional work was also required for renovation to significantly rehabilitate the existing facility due to the presence of asbestos in many areas of the building. Regarding the elimination of the 20% equity contribution, we find that the equivalent five million dollars would yield greater investment gains over a longer term than the interest that would be paid on a loan for a similar amount over the same time period…"

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve with condition the request by Sherrill House, Inc. to increase the maximum capital expenditure (MCE) of consolidated DoN Projects No. 4-1390 (Frank Wood Convalescent Home) and No. 4-1397 (Sherrill House, Inc.) to $27,023,473 (May 2001 dollars) and eliminate a condition of approval.** This amendment is subject to the following condition:

All conditions attached to the original and amended approval of Projects 4-1390 and 4-1397 shall remain in effect except for the condition requiring 20% equity contribution toward the MCE, which has been eliminated.

The approved MCE of $27,023,473 (May 2001 dollars) is itemized as follows:

	$
Land Costs:	
Land Acquisition	593,843
Site Survey and Soil Investigation	59,500
Other Non-Depreciable Land Development	1,194,381
Total Land Costs	1,847,724
Construction Costs:	
Depreciable Land Development Cost	2,915,118
Construction Contract (including bonding cost)	
New Construction	7,338,183
Renovation	8,148,973
Fixed Equipment not in Contract*	
Architectural & Engineering Costs*	
Pre-& Post-filing Planning & Development	242,262
Other: Asbestos Abatement	1,537,850
Other: Temporary Kitchen Location	76,500
Other: Project Management	573,298
Net Interest Expense During Construction	2,701,351
Major Moveable Equipment	998,468
Total Construction Costs	24,532,003
Financing Costs:	
Costs of Securing Financing	643,746
Total Financing Costs	643,746
Total Estimated MCE	$27,023,473

- Included in construction contract

The meeting adjourned at 11:05 a.m.

_____

Howard K. Koh, M.D., MPH
Chairman
Public Health Council

LMH/SB